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ABSTRACT

A 1984 survey of teachers and principals revealed that the respondents considered the use of drugs and alcohol to be the worst type of discipline problem they had experienced. While the significance of the drug and alcohol abuse problem in schools supports the existence of drug abuse prevention programs in the schools, several practical reasons also exist for conducting such programs within the school environment. The school setting provides well-organized classroom groups, promotes efficiency and cost effectiveness, and allows for longitudinal studies and trend analyses. Consequently, drug programs have become a part of contemporary education. When drug education programs were first introduced, they often relied on scare tactics. Materials focused on illegal drug use and overlooked alcohol, tobacco, and food additives. Teachers, for the most part, were untrained and poorly equipped to teach drug education. This document traces changes in drug education programs over the past 25 years and reports results from several studies on drug use among school-aged children and adolescents. Studies examining reasons that students use drugs and exploring characteristics of drug users are also reviewed. Various guidelines for developing and implementing drug education programs in the schools are discussed. The document concludes by stressing a need to restructure schools, families, and churches to focus on the needs of children. (NB)

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in

Drug Abuse Programs

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The Role of Education in Drug Abuse Programs

"Whenever a social problem needs correcting, education is the first idea put forth", (Sheppard, 1984, p. 323). Drug abuse is a serious societal problem. Thus, it is a challenge that elementary, middle, and secondary principals must confront. According to Narak (1987), "We need drug education programs in our schools if we do not want to see reading, writing, and arithmetic replaced by alcohol, marijuana, and cocaine" (p. 23).

Drug education programs should be conducted in schools for practical reasons. The school setting allows for efficiency in coordination of programs. Schools provide nicely organized classroom groups. The availability of large numbers of adolescents assumes cost effectiveness. Furthermore, the school environment allows assessments to be made on base rate use and track changes in substance use over time (Sheppard, 1984).

According to a 1984 ERS Staff Report, drug abuse programs must be conducted in the schools because the use of drugs and alcohol is a significant problem in today's schools. Their survey of teachers and principals revealed that theft, physical attacks, extreme verbal abuse, and vandalism are not considered the major problems. The worst type of discipline problem is the use of drugs and alcohol by adolescents.

Thus, the drug programs are a part of today's education. Floyd and Lotsof (1978) reported that prior to 1960 drug use had a very low status in the curriculum. However, as drug use increased, people became more concerned. Drug programs were forced into schools by society.

In the early days of drug education programs, scare tactics were employed. Students were taught that drugs would damage brain cells, cause insanity, and marijuana would lead to heroin addiction (Floyd & Lotsof, 1978). Ex-addicts or police officers were brought into the schools as guest speakers. They told their audiences about "the certain hell that awaits the habitual user" (Sagor, 1987, p. 7).

In 1972, the National Association Task Force on Drug Education reported that commerical agencies had taken advantage of the hysteria. The Task Force concluded that these agencies had not properly researched the issues. Thus, poor quality materials were being used in the schools. The drug education programs were based on this barrage of materials and films. The materials focused on illegal drugs. They overlooked socially acceptable drugs such as alcohol, tobacco, and food additives (Floyd & Lotsof, 1978). Furthermore, teachers were not trained to teach drug education programs. As a result, they presented factual material to the students without giving any attention as to why adolescents act as they do (Floyd & Lotsof, 1978). In addition, Kastl & Kastl (1975) identified the biggest problem of the past drug programs as being the

distributors of the information--the teachers. They agreed with the findings of Floyd and Lotsof in that teachers were poorly equipped and undereducated. Kastl & Kastl added that teachers were often scared, threatened, suspicious, and given these responsibilities without even wanting them.

Thus, Kearney (1979) reported that the scare tactics and disseminating information about the evils of drugs were counter productive. The aim was to prevent drug abuse by using fear as the motivating factor. It was assumed that disseminating information about drugs would further the prohibition and control of illegal drugs. Educators believed that no reasonable person would use drugs--forgetting the community of cigarette smokers and heavy drinkers (Jaffe & Clark, 1974). The unexpected results included mistrust, paranoia, cynicism, and an increased desire to experiment with drugs among students (Kearney, 1979).

Another problem that the early drug programs experienced was mistrust of education by the community. Society wanted educators to address the drug problem, yet the expected role that education should play was unclear. It was unclear if education should include training, indoctrination, propaganda, or search for truth (Arndt & Blockstein, 1970).

Reports of early drug education programs indicate that "many of the educational programs sponsored by our school systems are notoriously ineffective" (Sorensen, 1972, p. 28). Furthermore, we must not automatically assume that all drug

education programs in schools are good. Some of the programs are still inappropriate.

Regardless of setbacks in developing sound educational drug programs, it must be remembered that drug abuse has no socioeconomic or demographic boundaries (Carr, 1982). According to Nancy Reagan (1986), "Drug abuse is one of our most democratic problems. It has invaded all segments of society, crossing all lines of race, ethnic background, religion, and economics. No area of society has been left untouched by the growing menace of drug and alcohol abuse" (pp. 38-39). As a result, we must strive to improve our drug education programs.

Kearney (1979) suggested that drug programs be started in lower elementary grades. The reason being once children are introduced to drugs, the program becomes rehabilitation rather than prevention.

Narak (1987) agreed with Kearney in providing early prevention programs. Narak stated, "Drug use can be stopped at any stage. However, the more involved children are with drugs, the more difficult it is for them to stop. The best way to fight drug use is to begin prevention efforts before children start using drugs" (p. 25). Furthermore, the most effective means to fight drug use is to focus preventive efforts on young children. Narak said it is never too early to introduce drug and alcohol abuse to children.

Vissing (1978) reported that elementary students may not be using heroin, but they may be involved with physically damaging substances. Some elementary students experiment with alcohol and inhalants.

Langer (1976) said the highest priority for health education was EARLY drug awareness programs. Langer insisted that by the sixth grade, students should "understand the effect of ingesting dangerous substances, the value of medication, the reason for legal controls of drugs, and the social and legal consequences of drug abuse" (p. 59).

Carr (1982) summed up what many writers on drug abuse have said: "The old adage 'an ounce of prevention is worth a pound of cure' seems appropriate when discussing drug use" (p. 13). Thus, the objective of drug education is to prevent or alleviate drug use or drug abuse (Sheppard, 1984). Education can be used as one preventive measure for drug abuse; but with drug education, there must be a curriculum for all grade levels that goes beyond the classrooms to life applications (Carr, 1982).

Evidently, drug education programs have improved some over the past 25 years. There have been signs of progress. The 1985 findings of the National Institute on Drug Abuse of High School Senior Survey showed 1 in 20 seniors use marijuana on a daily basis, and the same number uses alcohol daily. Even though that is high, it is a decline in the overall use since the peak years of the late 1970s. Daily use of marijuana by

seniors is now less than one half of which it was then. The daily use of alcohol has steadily declined. It is an improvement, but we still have a long way to go (Reagan, 1986).

Sagor (1987) also reported that drug abuse had declined steadily among the school age population since the 1970s. Sagor indicated that the use of alcohol had not declined. Furthermore, Sagor concluded that the decline in drug abuse was associated with the decrease in alienating factors in American high schools and the re-emphasis on the nurturing relationship of the family.

Even though a few optimistic reports on the decline of substance abuse have been published; other reports are not so encouraging. For example, Schwartz (1985) reported that the frequent use of marijuana by adolescents was alarming. Schwartz revealed that in Montgomery County, Maryland, 2% of 1,400 eighth graders admitted to daily marijuana use for at least one month during 1984.

Another study by Narak (1987) indicated that drug and alcohol abuse is still one of the greatest challenges that our society faces today. The study in Nebraska revealed that over 82% of high school seniors and over 54% of those students in junior and middle schools reported the use of alcohol. Narak reported that there is a rise in the number of elementary school children using alcohol and other drugs--particularly marijuana. Narak added that the National Federation of Parents

for Drug Free Youth reports that there are 3.3 million teenage alcoholics in the United States.

Another discouraging finding by Sheppard (1984) indicated that there is a slight overall increase in smoking. Smoking is declining among adult males, but increasing among adult females.

In 1984, Severson reported that the use of marijuana was increasing. He found that 60% of high school seniors have tried marijuana, and 21% use it on a weekly basis.

In 1985, Schwartz explained the stages that marijuana users go through in an attempt to help educators, parents, and others deal with and help the person using drugs. In Phase 1, the user learns to experience the high. Sometimes, there are physiological symptoms such as anxiety, nausea, headache, palpitations, dizziness, weakness, and intense fear of loosing control or dying. In Phase 2, the user seeks the high. The user keeps his or her own supply of marijuana. There is usually a positive mood swing. There are three characteristics of chemical dependence in Phase 2: (a) experiences pleasant feelings, (b) alters degree of emphoria by varing the potency of the drug or means of using it, and (c) gets high every time drug is used and comes down safely. The user develops a trusting relationship with the drug. This in turn involves more fear, guilt, and deception. The user avoids "straight" friends and associates more with friends who use drugs. In Phase 3, there is a preoccupation with marijuana use as a way

of dealing with stress. After the user gets high, there is a feeling of irritability, depression, and apathy. In this phase, the user related negative feelings to parents, teachers, and others instead of the drug. Thus, the user returns to the drug for the pleasure that the high gives. This circle indicates true chemical dependence.

According to Schwartz (1985), school age children can get to Phase 3 because there is a history of alcoholism in the family, emotional immaturity, cannot cope with stress, and repeated repressing of anger or guilt. Self depreciation is a definite antecedent to chemical dependence. However, many children have none of these known or suspected risk factors. Some children try drugs because of peer pressure, curiosity, or adolescent rebelliousness.

Sagor (1987) suggested that some children use drugs because there is an adult authority vs. teenage culture. These children are exploring their world. They are trying to understand society and cope with stress in their lives. Sagor further added that the root cause of drug abuse is alienation among different categories of people: native Americans, youth of the 1960s, underemployed, young professional athletes, etc.

In an attempt to explain why youngsters experiment with drugs, Schwartz (1985) said they are curious about experiencing the high. Even though many have moral, social, and religious values, and they fear harming their bodies and getting caught, they try marijuana. They overcome barriers by persuasion,

pleading, daring, or teasing of friends. They are even more likely to try marijuana if their guard has been already weakened by alcohol.

In 1979, Kearney said that drug users have low feelings of self worth. They are unable to solve personal problems. Our task is to help students feel better about themselves, understand their own values, and teach them decision-making skills. If educators could do this, adolescents would have little or no use for drugs.

Narak (1987) did a study on how drug use develops. The study found that all students tried drugs because they want to fit in with others. Students in grades 4 and 5 reported that they tried drugs so they would feel older. The reason for trying drugs in grades 6-12 was to have a good time. The study further revealed that television and movies motivated fourth graders to try drugs; whereas, after grade 5, peers were the motivating force. Narak concluded that this finding reinforces the need for preventive programs in early grades. Programs are needed that focus on teaching children to resist peer pressure. Narak also noted that more worthwhile drug-free activities should be provided for school children.

Schwartz (1985) indicated that parents and teachers may have no indication that a child is using drugs. Schwartz stated that with experimental or occasional use the actions, dress, and academic achievements are usually unchanged. However, if the adolescent is preoccupied with getting high,

noticeable signs occur. There is estrangement from family, moodiness, deterioration of moral values, apathy, academic underachievement, school attendance problems, defense of drugs and drug culture, and a shift in peers. The physical characteristics of drug users include signs of intoxication or inebriation, glazed eyes, confusion, drowsiness, conjunctional hyperenia, and inappropriate silliness. Other characteristics might include display of unusual degrees of activity or excitement, excessive laughter, unusual talkativeness, unpredictable outbreaks of temper, associations with known or possible drug users, and appearance of intoxication with no smell of alcohol (Oshodin, 1984).

According to Flood and Morehouse (1986), teachers should recognize certain symptoms as drug-related. Referrals can be based on poor class attendance, decrease in classroom performance, sleepiness in class, and erratic behavior or mood shifts.

Sheppard (1984) reported on a study conducted by Jessor and Jessor in Colorado relating to values and drug abuse. They concluded that "the best predictors of drug taking was the value one placed upon education and expectation of success through education" (p. 326). Furthermore, the students with lower grades were usually the heavy drug users.

Regardless of the reasons that a child uses drugs, the impact on the whole family is great. Each family member reacts differently. Each person adopts his or her own defensive

coping mechanisms. Some family members tend to alienate the member of the family who is using drugs. Others deny that the drug problem even exists. Others nag and plead with the drug user, become workaholics, or overindulge the drug user by bailing him or her out of trouble (Schwartz, 1985). The whole family is affected by drug abuse.

Thus, drug abuse is not just an individual's problem. The problem affects the home, school, and community. Therefore, drug education is the responsibility of the whole community. "Education does occur outside the school" (Chng, 1981, p. 16). The media, peer groups, and family transmit their versions of drug education. These versions may not be in complete agreement with the drug education program that is taught in school.

Nevertheless, parental involvement is very important (Reagan, 1986). A child's informal drug education starts long before he or she encounters a program in school. Education or school is only one place to learn about drugs. Korn (1978) did a study to determine the extent to which first and third grade children have developed a concept of drugs. Concepts were formed by first and third graders. Korn concluded that second grade was a good time to begin drug education efforts. Korn added that informal sources may misinform children.

The drug issue required continuous awareness and scrutiny (Edwards, Arif, & Jaff, 1983). "The combined talents of educators, physicians, pharmacists, and law enforcement

officials must be utilized in presenting an effective and acceptable education program aimed at all levels of our population" (Arndt & Blockstine, 1970). The schools do not have the total responsibility for controlling juvenile behavior (Langer, 1976).

"Local needs make a big difference in developing drug policies" (Langer, 1976, p. 57). Communication between schools, community members, and organizations is extremely important. School administrators need to become informed about drug concerns through school and community functions and surveys of parents. All available community resources need to be noted and used (Carr, 1982).

School administrators also need to develop a positive working relationship with the school psychologists. Two major roles of school psychologists in the drug programs are prevention and referral/treatment. Working as a team, the administrators and psychologists can sensitize school staff and students to the drug problem. Teachers can be trained. Units can be developed for drug prevention. Parents can be informed about the school's drug education program (Severson, 1984).

The school's preventive approach has to be unique to their own resources, time, availability, support, and situation (Carr, 1982). However, increased communication between school administrators and substance abuse agencies will help with the coordination of drug abuse programs. According to Vissing (1978), "substance programs have a definite role in the school

system, and the expansion of quality programs in conjunction with local substance agencies is desirable" (p. 267). Help can be obtained through various agencies and organizations. Some of these include parent organizations--National Federation of Parents (NFP), Parents' Resource Institute for Drug Education (PRIDE), parent-teacher associations, rap centers, etc. (Reagan, 1986; Oshodin, 1984). Other groups that can aid in effective policy development include mental health and social agencies, police departments, community groups, prosecutors, courts, juvenile authorities, and student organizations (Langer, 1976).

In short, a formal policy for handling drug programs and drug abusers is needed to protect students, teachers, administrators, and the community. The policy should be affected by many factors. The development of a policy should be a cooperative effort which includes participation of agencies outside the schools. State and local laws must be obeyed. Community views must be respected. Continuous evaluation of exiting counseling treatment, education, and rehabilitation programs must be conducted by school administrators. The whole school drug education program should be evaluated including teacher training, student activities, materials, involvement of outside personnel, counseling and guidance, and emergency measures (Langer, 1976).

In 1982, Carr identified five steps for schools to follow to deal effectively with drug use. They include the following:

1. We must become informed.
2. Knowledge must be put to use in our daily experiences.
3. Recognize a problem when it exists.
4. Teach preventive drug use.
5. Have a definite plan or policy of action. (p. 12)

Advice was also offered by Oshodin (1984). To overcome obstacles in drug education programs, administrators must first learn the needs of the population. After the needs are known, get students involved in the program planning and research effort. The students should help assess needs, define program objectives, organize and promote, and evaluate the program.

According to Langer (1976), "most important in a school drug abuse prevention policy is to protect students from involvement with drug abuse, provide a realistic educational program to prevent drug abuse, and keep as many children as possible out of the criminal justice system" (p. 57). There is no easy formula to follow in policy making. Each situation has to be analyzed (Carr, 1982). However, Langer (1976) listed 13 items that an effective policy should include:

1. In-service training of teachers and staff
2. Communicate on policies and programs with the community
3. Safeguards for due process for students
4. Reasonable suspension and expulsion policies
5. Procedures for working with non-school agencies
6. specific procedures for police-school cooperation

7. Guidelines for the school education program on drugs
8. Extent and limitations on confidentiality of student and counselor
9. Delineation of roles of teachers and administrators in handling drug abusers, reporting illegal activity, school-community-policy relations, etc.
10. Steps for noncompliance with policy by employees
11. Procedures for emergency problems
12. Positive roles for students and student organizations
13. Referral procedures for actual and suspected drug-use cases. (p. 59)

Along these same guidelines, Flood and Morehouse (1986) emphasized the importance of administrators setting the right climate to prevent drug abuse. School functions that have been associated with drug abuse should not be held. Well-chaperoned class days should be sponsored. Plenty of food, activity, and student-teacher contact should be a part of class days. Administrators should talk to student groups openly about their concerns of drug safety before proms and end-of-the-year events. Furthermore, administrators should support identifications, screening, and referral activities made by their staff. All students should be disciplined equally and consistently according to policies. Alcohol and substance abuse programs should be explained to parent groups. Most importantly, a strong policy regarding the handling of students

using or possessing alcohol or drugs at school or school functions must be established.

Donovan (1981) discussed many of the same issues as Flood and Morehouse and Langer on drug policy. In addition, Donovan addressed the money issue. The cost of the drug prevention program must be kept as low as possible. Funding must be continually sought from a variety of sources. Donovan also noted that optimism must be the prevailing mood. According to Floyd and Lotsof (1978), a comprehensive drug education program must contain all of the following if it is to be effective:

1. Prevention
2. Appraisal and screening
3. Diagnosis
4. Treatment
5. Rehabilitation
6. Evaluation (p. 361)

However, Chng (1981) reported that drug education in the schools has failed. According to Chng, the failure comes with the goal of abstinence. This has sabotaged the success of the programs. This is not a realistic goal for an educational program, especially when we have a "drug saturated society", which promotes and accepts drug use for trivial discomforts (p. 15).

Furthermore, Chng (1981) said that a double standard works against the credibility of the drug programs. Chng indicated that adolescents were told not to use drugs while alcohol,

nicotine, caffeine, and presciption drugs were not placed in the same context as youthful recreational drugs.

Zinberg (1984) also noted that drug education and prevention programs should be broader to include alcohol and tobacco. Zinberg concluded, as did Chng, that to ignore these drugs destroyed the credibility of the program.

Severson (1984) saw the same problem with chewing tobacco. There was no public program focused on the use of chewing tobacco until only recently. Schools have finally become alarmed by the increasing use among male teens. Funding agencies have started to respond to this threat.

Sagor (1987) reported that society makes a difference between alcohol and other substances. Sagor called for an end to this. Alcohol is a drug.

However, Severson (1984) reported that drug programs which focus on teaching refusal or social skills have shown a reduction in subsequent alcohol consumption. Programs should focus on affective or attitudinal change toward abusive drinking like the CASPAR. The CASPAR is an alcohol education program implemented in two communities in Massachusetts which has shown positive results. The curriculum was developed in three modules for grades 3-6, 7-9, and 10-12. There were 5-10 class periods.

There are organizations which are concerned about abusive drinking. Some of these organizations include Mothers Against

Drunk Drivers (MADD), Remove Intoxicated Drivers (RID), and Students Against Drunk Driving (SADD) (Gerstein, 1984).

Thus, an effective drug education program must address all drugs--including alcohol and chewing tobacco. Children must be given accurate information about drugs--prescription vs. non-prescription, legal or illegal, psychologically or physically dependent, and helpful vs. harmful (Kearney, 1979).

Korn (1978) reported that many drug education programs were aimed at teaching about potentially harmful effects of drugs as well as positive therapeutic users. Students should be provided information on how to avoid the effects of destructive drug combinations, unpleasant consequences of using drugs of unknown purity, hazards of using drugs with a high dependence, dangers of certain methods of administration, and unexpected effects of various dose levels (Zinberg, 1984).

Cotten-Huston (1982) studied the interests of junior high school students relating to drugs. The students' interests and concerns included the following topics:

1. Help and rehabilitation
2. Drug traffic and production
3. The law, stealing, prison
4. Physiological effects
5. The money hassle
6. Age and sex of drug users
7. The addictive process
8. The hows and whys of stopping

A drug education program will succeed only with good organizational and promotional skills. Furthermore, a drug educator must be dynamic (Oshodin, 1984). "The common result of programs led by untrained substance personnel is failure" (Vissing, 1978, p. 268). Well-meaning clergy, social workers, and policemen are not qualified to teach drug education programs (Vissing, 1978). Drug educators should be able to stimulate and guide inservice education. They should also possess a code of ethnical practice (Oshodin, 1984).

Teachers must have the knowledge about drugs and the ability to communicate with kids. Experts should be hired to train teachers about the patterns of drug use and lifestyles in subcultures with which they are unfamiliar (Kastl & Kastl, 1975).

Alcohol and Drug Education (ADE) program originated in Chicago in 1979. This program was designed to train teachers from public, parochial, and alternative elementary schools about substance abuse. The general topic areas of workshop sessions included:

1. General overview of alochol and other drugs.
2. Alcohol - BASIC information.
3. Other drugs - BASIC information.
4. Values clarification.
5. Assertiveness training.
6. Treatment of alcohol and other drug abuse.
7. The alcoholic family.

8. A. A., Alanon, Alateen, and Families Anonymous.
9. Legal issues in the classroom.
10. Minorities and substance abuse.
11. Field trips to area alcohol and drug training facilities.

Workbooks were compiled. They included basic drug information, values clarification exercises, assertiveness training, area treatment, referral and speaker resources, films and materials available for loan from state's library, suggested classroom activities, and sample lesson plans (Sherman, Lojkutz, & Steckiewicz, 1984).

Not only should teachers attend inservice programs conducted by trained substance educators, but parents should be involved. Classes should be available to parents on topics in substance abuse and education (Vissing, 1978).

Severson (1984) noted that alcohol prevention programs were more effective when conducted by trained personnel and if the programs were targeted at high-risk students. The student population should not be seen as a homogenous group. Each individual will not respond to the program in a given way even though the message was the same. Programs should be designed for high-risk individuals, abstainers, fence-sitters, drug abusers, emotionally distraught persons, the curious, and the defiant (Chng, 1981).

Once again, communication cannot be overemphasized. Words have different meanings to different people (Arndt &

Blockstein, 1970). Even though drug education is compulsory in most schools, the process varies greatly. A simple lecture with factual information about the effects of drugs is not enough for all students (Sheppard, 1984). School administrators must take a long, hard look at the way they are communicating with the students. The drug education programs must be evaluated in terms of state objectives so that necessary amendments can be made in the drug programs (Oshodin, 1984).

According to Oshodin (1984), drug education programs should develop human interaction and relationships. A humanistic approach should be used. Communication about drug programs should flow freely in local school newspapers and pamphlets. Films should be used, as well as workshops and seminars which include role playing.

Floyd and Lotsof (1978) suggested that in planning and implementing a valuable drug education program the basic human needs concept be included. Understanding psychological needs is the basis of the human needs concept. This is the key to understanding human motivation. Educators should try to understand why an adolescent has resorted to drug use. Some reasons might include alienation, psychic conflicts present during adolsecence, anxieties about dating, sexuality, homosexuality, etc.

Carr (1982) recommended that educators be aware of the turbulence, turmoil, and pain of the maturation process.

Adolescents have a rough time with the socialization process, too. Be supportive of them in their daily and academic lives. Provide adequate curricular and extracurricular activities. "By fostering a friendly and empathetic environment our attempt at preventing drug use is enhanced" (Carr, 1982, p. 13).

Sheppard (1984) concluded that drug education programs must include more than information. Educators need to include assessment of the influences and how to do assessment of the influences causing drug usage. Values clarification, decision making, coping, and extra academic help are all a part of this process. Schools have limited time to teach the basic skills; therefore, what is needed is integrated growth-oriented programs. More add-on courses are not necessary. "The primary advantage of the correlated approach may be the fact that the drug problem needs a multi-disciplinary education attack" (Oshodin, 1984, p. 20).

Floyd and Lotsof (1978) stated that drug education programs should focus on positive factors. Educators should strive to teach the importance of increasing the quality of life rather than causing people problems. We should teach that drugs are neither good nor bad. The content of the programs should be inclusive rather than exclusive.

Oshodin (1984) argued that drug knowledge must be presented in an acceptable and comprehensible manner. Emotional needs and wants, cultural attitudes, beliefs,

prejudices, fear, and values must all be considered in the implementation of any drug program.

Drug education programs have been fragmented and poorly planned (Floyd & Lotsof, 1978). In many cases, programs have been developed around perceived needs instead of actual, documented needs (Vissing, 1978).

On the other hand, some drug education programs have tended to be effective. Some effective programs focused on social skills in a multi-component prevention program. Other programs taught specific life skills or refusal skills. Assertion training has also proved effective. Regardless of the type of programs, the central strand emphasized teaching social skills and prepared adolescents to deal with peer pressure (Severson, 1984). This has been more effective than the more direct programs. The more direct programs increased knowledge about the effects of various substances; however, there was little change in students' attitudes toward and use of substances (Vissing, 1978).

Chng (1981) suggested that in order to prevent drug programs from failing, educators evaluate them more carefully. Chng noted that evaluation was difficult because often program goals are not clearly expressed. Furthermore, Chng (1981) discussed various drug programs including scientific information about drugs, values clarification, decision making, self-concept development, attitude modification, and social

alternatives. The implicit goal of them is the reduction and eventual elimination of all unsanctioned drugs.

According to Vissing (1978), the type of program made all the difference to success. Programs based on the indirect approach to prevention increased students' self-concept and build self-esteem. The indirect approach was the most effective in prevention programs. Vissing added, "The factual approach to substance education appears to far outweigh the crusading, moralistic approach" (p. 268). This approach leads to the scare tactics of the 1960s and 1970s.

Cotten-Huston (1982) noted that there are many diverse approaches used in the drug education programs. Some programs used peers, brothers and sisters, and ex-addicts. Peer-led programs demonstrated a preventive effect (Severson, 1984). These programs were difficult and expensive to implement. Therefore, teacher-led programs with peer assistance was suggested by Severson (1984).

Severson (1984) reported that Botuin's study revealed that his Life Skills Training for seventh graders had a significant impact on reported marijuana use. Peer-led treatment reduced total marijuana use by 71% and regular weekly use by 83%. Severson also reported that Horan and William's assertiveness training significantly affected reported willingness to use alcohol or marijuana. It had a significant effect on decreasing their use at follow-up. This study included 148 eighth graders.

Gill (1983) recommended that educators conduct drug education programs in relation to reality. Scare tactics were not suggested. However, Gill recommended that students be taken to hospitals to look at people whose minds no longer functioned. In turn, this would teach the students to be thankful for having good, clear minds. Gill also suggested having Career Days at school to gain positive peer influence. The peers with high goals would serve as role models.

Reagan (1986) suggested supplementing regular drug education classes with knowledgeable speakers. She recommended students be taught about the problem with the law by inviting enforcement officers in to speak. She also suggested health professionals and personalities from the sports' and entertainment fields address student assemblies. She is strongly in favor of forming positive peer pressure groups such as the "Just Say No" clubs.

Sagor (1987) disagreed with the Reagan approach. According to Sagor, ex-addicts or police officers speak to student assemblies about "the certain hell that awaits the habitual user" (p. 86). This approach proved counter-productive in the 1960s and 1970s. It internalizes the message that the tough can survive, speak at schools, and make lots of money as a result. Thus, Sagor suggested that educators can help by reinforcing the credibility of adults. "As a gesture of respect we should all agree to lower our voices a few decibels" (Sagor, 1987, p. 86).

In agreement with this approach, according to Snider (1987), is Maurer. Maurer's approach centers on the teaching of values rather than on the negative effects of using drugs. Maurer says stop shouting at students and get to the underlying issue of self-respect. An example of Maurer's tactics is: "What do John Belushi, Len Bias, and Janis Joplin have in common? They used drugs, and they're dead" (Snider, 1987, p. 12).

There are a few new prevention efforts that depart from traditional approaches. There is a theory of a drug-free existence by promoting interest in such natural highs as yoga, meditation, and other nonchemical experiences (Zinberg, 1984). Yet, there is controversy about these approaches, too.

In short, there is no argument on a best approach to teaching drug education programs. Nevertheless, there is consent from most of society that these programs must be a part of the school's responsibility. Thus, "clarifying the role of the school in a comprehensive drug program is important when we realize the contributions an educational agency can make" (Floyd & Lotsof, 1978, p. 361). Education's major contribution is certainly in the area of prevention. Yet, we must remember that "schools cannot operate in an awareness, information, action vacuum and be effective" (Floyd & Lotsof, 1978, p. 361). The whole community must be involved in effective drug programs.

Education is seen by many as the key to preventing drug abuse. Children must learn the truth about drugs and how to say no (Reagan, 1986).

We may need to restructure our school, families, and churches to focus on our children's needs. Drug abuse must be seen as a social and not a medical problem. We must work together to develop a child-centered society. Our children need our time and unconditional love. "To achieve a lasting peace in the war on drugs we must make peace with our children" (Sagor, 1987, p. 87).

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